DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Medical Marijuana Program

DPH/HSP office use only
Date received _____ Issue date _____
Staff initials _____ Expiration date _____
☐ Approved ☐ Denied App/den date _____

Please print clearly. Caregivers must be Delaware state residents and have a state-issued driver's license or identification card. Incomplete applications will be denied. Caregiver applications are only accepted as a supplement to a patient's application. Please put "N/A" if not applicable. **Application fees are non-refundable. Faxed and electronic copies will not be accepted.**

Caregiver Application

☐ New caregiver ☐ Renewing caregiver Current Registry ID Card # _____

CONTACT INFORMATION

Date of birth _____ Gender ☐ Male ☐ Female
Must be at least 21 mm / dd / yyyy

Name _____
Title First Middle initial Last Suffix(es)

(This name must match the name on your state-issued photo identification or driver's license.)

Residence address The address provided below must be your physical residence and will appear on your registry card.
Apt#/development/apartment name _____
Street address/post office box # _____
City _____ State _____ County _____ ZIP code _____

Mailing address ☐ Check if mailing address is the same as residential.
Apt#/development/apartment name _____
Street address/post office box # _____
City _____ State _____ County _____ ZIP code _____

Primary phone number _____ Type of phone (home, cell) _____
Secondary number _____ Type of phone (home, cell) _____

E-mail address _____

Note regarding E-mail: Please note that confidential and time sensitive information will be sent to this e-mail address. Failure to respond to e-mails may result in your application being delayed, withdrawn or denied. It is the applicant's responsibility to add MedicalMarijuanaDPH@state.de.us to their list of safe senders to avoid having messages sent to their junk e-mail folder. Instructions on how to add an e-mail address to your list of safe senders can be found in your e-mail provider's documentation. ***It is not required that you submit your e-mail address***.

PATIENT INFORMATION

The following information relates to the patient. A caregiver must complete this Caregiver Application for each patient they wish to assist with the medical use of marijuana. The patient will then submit the form to the program for review. A caregiver may have up to five (5) patients including himself/ herself in the case that they are also a patient.

Name _____
Title First Middle initial Last Suffix(es)

Address
Apt#/development/apartment name _____
Street address/post office box # _____
City _____ State _____ County _____ ZIP code _____
Phone number _____ Phone type (cell/home) _____
Date of birth _____ (mm/dd/yyyy) Gender ☐ Male ☐ Female
Relationship to caregiver: _____
Patient's Medical Marijuana registry ID# if known: _____

APPLICANT DEMOGRAPHIC INFORMATION

It is the policy of the state of Delaware to assure equal and fair treatment in all aspects of healthcare for all of our residents. The information on this page will only be used to document and assess the effectiveness of our outreach and will not be used for eligibility determination. Your voluntary answers are requested. Thank you.

Marital Status

What is your current marital status?

a. __ Single b. __ Married/Civil Union c. __ Divorced
d. __ Separated e. __ Widowed f. __ Unmarried partnership

Ethnicity

Which of the following best describes your ethnicity?

a. __ Hispanic or Latino b. __ Non-Hispanic or Latino

Race

Which of the following best describes your racial heritage?

a. __ Caucasian/White d. __ African American/Black
b. __ Asian e. __ American Indian or Alaska native
c. __ Native Hawaiian or pacific islander f. __ Other

Language

How well do you speak English?

a. __ Very well b. __ Well c. __ Not well d. __ Not at all

Do you speak a language other than English at home?

a. __ No b. __ Yes, Spanish c. __ Yes, not Spanish, please specify: _____

Veteran Status

Are you a United States veteran?

a. __ Yes b. __ No

Citizenship

Are you a citizen or lawful alien of the United States of America? a. __ Yes b. __ No

Education

What is your highest level of education completed?

a. __ High school last grade completed d. __ Technical school
b. __ High school diploma/GED e. __ University or 4-year college
c. __ Community college/2-year degree f. __ Master program or above

Are you currently enrolled in school?

a. __ No b. __ Yes If yes, what level? _____

Employment

Are you currently working? a. __ No b. __ Part Time c. __ Full Time

What is your occupation? _____

Income

What is your annual household income?

a. __ Less than $20,000 d. __ $60,000 to $79,999
b. __ $20,000 to $39,999 e. __ $80,000 to $99,999
c. __ $40,000 to $59,999 f. __ $100,000 or above

Public Assistance

Are you currently enrolled in a public assistance program such as the DE food supplement program, health insurance, child care assistance, energy assistance program, or any other public assistance program?

a. __ No b. __ Yes Which program(s)? _____

Low Income Charge Request

If you believe that you qualify for the low income fee schedule, and wish to be considered for a lower application fee, you must provide supporting financial information, such as copies of your most recent tax returns, copies of W-2 forms, other documents showing current income. Total annual gross household income and the number of people living in the household will be requested in order to approve a reduced rate. To avoid denial of your application or delay in processing, please call the program to request a low income packet.

Required Documents

These documents must be submitted with your caregiver application - and only as a supplement to the patient's application:

Delaware driver's License or state-issued photo identification card

☐ ID number _____ Issue date _____ (mm / dd / yyyy) Expiration date _____ (mm / dd / yyyy)

A legible ***copy*** of your Delaware driver's license OR state-issued photo identification card should be ***sent*** with the application submission; the ***original document*** must be available for ***visual inspection*** when registry card is issued.

☐ Caregiver Application form ☐ Patient Authorization form

☐ **Copy** of caregiver's birth certificate (verifying caregiver applicant is at least 21 years old)

☐ Statewide and nationwide criminal history screening background clearance reports for the caregiver (for further information, contact the program)

Caregiver's Attestation Signature and Date

_____ (initial) I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.

_____ (initial) I agree to notify the Delaware Division of Public Health, Medical Marijuana Program, in writing (use the "Change Form"), within 10 days of any changes to the information provided.

_____ (initial) I attest that I will not divert marijuana to any individual or entity that is not allowed to possess marijuana pursuant to Title 16 of the Delaware Code, Chapter 49A - The Medical Marijuana Act.

_____ (initial) I attest that I am at least 21 years of age.

_____ (initial) I will assist, _____, a qualified medical marijuana patient, with the medical use of marijuana. I am caring for no more than five patients in this manner.

_____ (initial) I attest that I have not been convicted of an excluded felony offense as defined in Title 16, Chapter 49A - The Delaware Medical Marijuana Act.

_____ (initial) I understand that if the patient's registry identification card expires, then my caregiver card for this patient shall also expire. I agree to return my primary caregiver card to the Delaware Department of Health and Social Services if and when my patient(s) is(are) no longer eligible for the program or if my patient(s) change(s) caregivers.

_____ Caregiver signature _____ Date of signature

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Date received _____
Staff initials _____
Date verified _____
Staff initials _____

Patient verified with certifying physician?
☐ Yes ☐ No

Please print clearly. Patients, please complete and sign the following authorization statement. This authorization will designate your chosen caregiver. If this form is omitted, your caregiver's application will be considered incomplete and will be denied. **Faxed and electronic copies will not be accepted.**

Patient Authorization Form

AUTHORIZATION FOR CAREGIVER

I, _____, (the patient's printed name):
hereby authorize the following person to be my designated caregiver for the Delaware Medical Marijuana Program. I authorize this caregiver to assist me in the transportation and storage of my medical marijuana. This person will be responsible for managing my well-being with respect to the use of marijuana.

Caregiver's first name: _____ Last name: _____

Caregiver's date of birth: _____
Must be at least 21 yrs. old mm / dd / yyyy

_____ _____
Patient's signature Date of signature

417 FEDERAL STREET • JESSE COOPER BUILDING, SUITE 205 • DOVER DELAWARE 19901
(302) 744-4749 • MEDICALMARIJUANADPH@STATE.DE.US

CRIMINAL HISTORY RECORD CHECK AUTHORIZATION FORM
USE FOR APPLICANT PURPOSES
(PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK)

_____ _____ _____ _____
LAST NAME **FIRST NAME** **MI** **SUFFIX**

ALIASES: MAIDEN / PREVIOUS LAST NAMES

_____ _____ _____ _____

DATE OF BIRTH :_____/_____/_____ **SOCIAL SECURITY # _____-_____-_____**

SEX_____ RACE_____ HEIGHT_____ WEIGHT_____ EYES_____ HAIR_____

PLACE OF BIRTH (STATE/COUNTRY) _____ CITIZENSHIP (COUNTRY) _____

CURRENT ADDRESS: _____

CITY/STATE: _____ ZIP: _____

TELEPHONE NUMBER: Home/Cell: (_____)_____ Work: (_____)_____

*** COMPLETE IF MAILING RESULTS TO DIFFERENT ADDRESS OTHER THAN YOURSELF:**

NAME/COMPANY – Delaware Health and Social Services – Division of Public Health

ADDRESS: Jesse Cooper Building, Room 205 (HSP ADM) 417 Federal Street

CITY/STATE: Dover, Delaware 19901

ATTN: Medical Marijuana Program

AUTHORIZATION TO RELEASE INFORMATION:

As an applicant I authorize release of any and all information that you have concerning me, including CRIMINAL HISTORY RECORD INFORMATION and other information of a confidential or privilege nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage, which may result from furnishing this information:

SIGNATURE OF APPLICANT: _____ DATE: _____

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

OFFICIAL USE ONLY

_____
AGENCY

MEDICAL MARIJUANA ACT (MMA)
REASON FINGERPRINTED

_____/_____
Code Time